FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031393

Facility Name: SKOKIE MEADOWS N CENTER #2

Address: 4600 WEST GOLF ROAD (Number) SKOKIE (City) 60076 (Zip Code)

County: COOK

Telephone Number: (847) 679-1157 **Fax #** (847) 329-8633

IDPA ID Number: 36-3481217

Date of Initial License for Current Owners: 12/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JACOB GRAFF
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	111	Intermediate (ICF)	111	40,515	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,557	603	15,525	38,685	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,557	603	15,525	38,685	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.48%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	132,748	14,245	7,102	154,095		154,095		154,095			1
2	Food Purchase		138,591		138,591		138,591	(13,895)	124,696			2
3	Housekeeping	157,247	20,051		177,298		177,298		177,298			3
4	Laundry	73,357	9,914		83,271		83,271		83,271			4
5	Heat and Other Utilities			65,454	65,454		65,454	102	65,556			5
6	Maintenance		13,743	26,143	39,886		39,886	599	40,485			6
7	Other (specify):*			8,841	8,841		8,841		8,841			7
8	**TOTAL General Services**	363,352	196,544	107,540	667,436		667,436	(13,194)	654,242			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,032,541	201,098	51,563	1,285,202		1,285,202		1,285,202			10
10a	Therapy											10a
11	Activities	74,048	4,565		78,613		78,613		78,613			11
12	Social Services	146,885		4,654	151,539		151,539		151,539			12
13	CNA Training											13
14	Program Transportation			180	180		180		180			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,253,474	205,663	57,597	1,516,734		1,516,734		1,516,734			16
	C. General Administration											
17	Administrative	40,063		202,948	243,011		243,011	(93,270)	149,741			17
18	Directors Fees											18
19	Professional Services			15,601	15,601		15,601	4,657	20,258			19
20	Dues, Fees, Subscriptions & Promotions			16,646	16,646		16,646	(4,800)	11,846			20
21	Clerical & General Office Expenses	13,863	7,652	227,999	249,514		249,514	(168,852)	80,662			21
22	Employee Benefits & Payroll Taxes			339,269	339,269		339,269	13,797	353,066			22
23	Inservice Training & Education			490	490		490		490			23
24	Travel and Seminar			11,848	11,848		11,848		11,848			24
25	Other Admin. Staff Transportation			6,903	6,903		6,903		6,903			25
26	Insurance-Prop.Liab.Malpractice			77,495	77,495		77,495	5,863	83,358			26
27	Other (specify):*							8,019	8,019			27
28	**TOTAL General Administration**	53,926	7,652	899,199	960,777		960,777	(234,586)	726,191			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,670,752	409,859	1,064,336	3,144,947		3,144,947	(247,780)	2,897,167			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SKOKIE MEADOWS N CENTER #2 **#0031393** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,627	
	REPAIRS & MAINTENANCE		475	
			0	7,102
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,872	
	ELECTRICITY		31,840	
	WATER		2,742	
	CABLE TV - LOBBY		0	
			0	65,454
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		14,581	
	PAINTING & DECORATING		591	
	BUILDING REPAIRS		2,598	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,237	
	ELEVATOR MAINTENANCE & REPAIR		4,307	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,462	
	FIRE SERVICE		1,367	
			0	
			0	
			0	26,143
7	**OTHER**			
	SCAVENGER		7,148	
	SECURITY SERVICE		1,693	8,841
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,200	1,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		8,371	
	PURCHASED SERVICES		36,928	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,224	
	PHARMACY CONSULTANT	XVIII B 39-2	2,040	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	51,563
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,654	
			0	4,654
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 **#0031393** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		180	180
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	202,948	202,948
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	2,820	
	ADMINISTRATIVE CONSULTANTS	XIX C	4,000	
	PROFESSIONAL FEES	XIX C	8,781	
			0	15,601
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,302	
	EMPLOYEE WANT ADS	XIX F	2,809	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	6,237	
	LICENSES & PERMITS	XIX F	2,800	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,498	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	16,646
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,185	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		194,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		7,814	
	MESSENGER SERVICE		0	
	OUTSIDE SERVICES		24,000	227,999

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	125,981	
	UNEMPLOYMENT COMPENSATION	XIX D	15,809	
	WORKERS COMPENSATION INSURANCI	XIX D	21,849	
	HOSPITALIZATION INSURANCE	XIX D	147,188	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,664	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	21,778	
	CHICAGO HEAD TAX	XIX D	0	339,269
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		490	490
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	11,848	
			0	
			0	11,848
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,903	6,903
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		77,495	77,495
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,064,336

SKOKIE MEADOWS N CENTER #2
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	138,591
LESS SALES TAX	(98)
NET FOOD	138,493
TOTAL PATIENT CENSUS	38,685
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	116055
ADD # EMPLOYEE MEALS/DAY	35
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	12775

PATIENT MEALS	116055
ADD EMPLOYEE MEALS	12775
TOTAL MEALS/YEAR	128830
NET FOOD	138493
DIVIDE TOTAL MEALS/YEAR	128830
COST PER MEAL	1.08
TIME EMPLOYEE MEALS	12775
EMPLOYEE MEAL RECLASSIFICATION	13797

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 #0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			16,072	16,072		16,072	89,910	105,982			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,044	38,044		38,044	468,232	506,276			32
33	Real Estate Taxes			222,288	222,288		222,288		222,288			33
34	Rent-Facility & Grounds			528,748	528,748		528,748	(528,748)				34
35	Rent-Equipment & Vehicles			13,764	13,764		13,764	2,471	16,235			35
36	Other (specify):* **amort comp soft**			3,190	3,190		3,190		3,190			36
37	**TOTAL Ownership**			822,106	822,106		822,106	31,865	853,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,773	60,773		60,773		60,773			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			60,773	60,773		60,773		60,773			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,670,752	409,859	1,947,215	4,027,826		4,027,826	(215,915)	3,811,911			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	232	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,498)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(3,302)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(219,586)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (224,252)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	8,337		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 8,337		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (215,915)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SKOKIE MEADOWS N CENTER #2

ID# 0031393

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 599	6	1
2	BANK CHARGES	(2,185)	21	2
3	NON - ALLOWABLE TRAVEL			3
4	OUTSIDE CLERICAL-PREMIER	(194,000)	21	4
5	OUTSIDE SERVICES-1139 BEVERLY	(24,000)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(219,586)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(98)	0	0	0	0	0	0	0	0	0	0	(98)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	102	0	0	0	0	0	0	0	0	0	102	5
6	Maintenance	599	0	0	0	0	0	0	0	0	0	0	599	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	501	102	0	0	0	0	0	0	0	0	0	603	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(93,270)	0	0	0	0	0	0	0	0	0	(93,270)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,657	0	0	0	0	0	0	0	0	0	4,657	19
20	Fees, Subscriptions & Promotions	(4,800)	0	0	0	0	0	0	0	0	0	0	(4,800)	20
21	Clerical & General Office Expenses	(220,185)	51,333	0	0	0	0	0	0	0	0	0	(168,852)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,003	4,860	0	0	0	0	0	0	0	0	5,863	26
27	Other (specify):*	0	8,019	0	0	0	0	0	0	0	0	0	8,019	27
28	**TOTAL General Administration**	(224,985)	(28,258)	4,860	0	0	0	0	0	0	0	0	(248,383)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(224,484)	(28,156)	4,860	0	0	0	0	0	0	0	0	(247,780)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 **#** 0031393 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	232	0	89,678	0	0	0	0	0	0	0	0	89,910	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	468,232	0	0	0	0	0	0	0	0	468,232	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(528,748)	0	0	0	0	0	0	0	0	(528,748)	34
35	Rent-Equipment & Vehicles	0	2,471	0	0	0	0	0	0	0	0	0	2,471	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	232	2,471	29,162	0	0	0	0	0	0	0	0	31,865	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(224,252)	(25,685)	34,022	0	0	0	0	0	0	0	0	(215,915)	45

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFF	100	SKOKIE MEADOWS I	SKOKIE	PREMIER	SKOKIE	MANAGEMENT
		MOMENCE MEADOWS	MOMENCE	MANAGEMENT		BOOKKEEPING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 202,948	PREMIER MANAGEMENT		$	$ (202,948)	1
2	V	5	UTILITIES		PREMIER MANAGEMENT		102	102	2
3	V	17	OFFICER SALARIES		PREMIER MANAGEMENT		56,556	56,556	3
4	V	17	ADMINISTRATIVE SALARIES		PREMIER MANAGEMENT		34,709	34,709	4
5	V	17	ADMINISTRATIVE SALARIES		PREMIER MANAGEMENT		18,413	18,413	5
6	V	19	PROFESSIONAL FEES		PREMIER MANAGEMENT		4,657	4,657	6
7	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		19,344	19,344	7
8	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		15,175	15,175	8
9	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		13,015	13,015	9
10	V	21	OFFICE EXPENSE		PREMIER MANAGEMENT		3,799	3,799	10
11	V	26	INSURANCE		PREMIER MANAGEMENT		1,003	1,003	11
12	V	27	PAYR.TAXES/HEALTH INS		PREMIER MANAGEMENT		8,019	8,019	12
13	V	35	OFFICE RENTAL		PREMIER MANAGEMENT		2,471	2,471	13
14	Total			$ 202,948			$ 177,263	$ * (25,685)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 528,748	M O SKOKIE MEADOWS		$	$ (528,748)	15
16	V	26	INSURANCE				4,860	4,860	16
17	V	30	DEPRECIATION				89,678	89,678	17
18	V	32	INTEREST				468,232	468,232	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 528,748			$ 562,770	$ * 34,022	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	ADMINISTRATIV	100.00	SEE ATTACHED			SALARY	$ 56,556	17-7	1
2			BANKING			SEE ATTACHED					2
3			FINANCE								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 56,556		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 679-7733
Fax Number: (847) 679-7736

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	342,006	8	$ 900	$	38,685	$ 102	1
2	17	OFFICER SALARIES	PER RESIDENT DAY	342,006	8	500,000	500,000	38,685	56,556	2
3	17	ADMINISTRATIVE SALARIES	DIRECT	10	3	115,696	115,696	3	34,709	3
4	17	ADMINISTRATIVE SALARIES	PER RESIDENT DAY	342,006	8	162,786	162,786	38,685	18,413	4
5	19	PROFESSIONAL FEES	PER RESIDENT DAY	342,006	8	41,168		38,685	4,657	5
6	21	CLERICAL SALARIES	DIRECT	10	3	48,360	48,360	4	19,344	6
7	21	CLERICAL SALARIES	DIRECT	4	3	60,700	60,700	1	15,175	7
8	21	CLERICAL SALARIES	DIRECT	10	4	43,384	43,384	3	13,015	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	342,006	8	33582		38,685	3,799	9
10	26	INSURANCE	PER RESIDENT DAY	342,006	8	8,869		38,685	1,003	10
11	27	PAYR.TAXES/HEALTH INS	PER RESIDENT DAY	342,006	8	70,898		38,685	8,019	11
12	35	OFFICE RENTAL	PER RESIDENT DAY	342,006	8	21,844		38,685	2,471	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,108,187	$ 930,926		$ 177,263	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: M O SKOKIE MEADOWS NURSING
Street Address: 9615 N KNOX
City / State / Zip Code: SKOKIE,IL 60076
Phone Number: (847)679-7733
Fax Number: (847)679-7734

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	DIRECT	1	1	$ 4,860	$	1	$ 4,860	1
2	30	DEPRECIATION	DIRECT	1	1	89,678		1	89,678	2
3	32	INTEREST	DIRECT	1	1	468,232		1	468,232	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 562,770	$		$ 562,770	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$44,062.00	8/16/01	$ 6,822,050	$ 6,602,627	8/16/36	0.0710	$ 468,232	1
2												2
3												3
4												4
5												5
	Working Capital											
6	1ST EQUITY		X	WORKING CAPITAL	INT ONLY			500,000			38,044	6
7												7
8												8
9	TOTAL Facility Related				$44,062.00		$ 6,822,050	$ 7,102,627			$ 506,276	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,822,050	$ 7,102,627			$ 506,276	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 169,742	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 196,015	2
3. Under or (over) accrual (line 2 minus line 1).		$ 26,273	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 196,015	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 222,288	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	174,619	8
	2001	185,310	9
	2002	189,123	10
	2003	169,742	11
	2004	196,015	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKOKIE MEADOWS N CENTER #2 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031393

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-304-042-0000	NURSING HOME	$ 196,015.13	$ 196,015.13
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 196,015.13	$ 196,015.13

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,213 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 341,425	1
2					2
3	TOTALS			$ 341,425	3

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	111		1990		$ 1,934,075	$ 61,399	31.5	$ 61,399	$	$ 944,048	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS			1987	1,200	38	15		(38)	1,200	9
10	IMPROVEMENTS			1987	1,353	43	20	67	24	1,235	10
11	IMPROVEMENTS			1987	2,329	74	10		(74)	2,329	11
12	IMPROVEMENTS			1989	6,500	206	31.5	206		3,441	12
13	IMPROVEMENTS			1990	159,219	5,055	31.5	5,055		76,791	13
14	IMPROVEMENTS			1991	1,680	53	31.5	53		799	14
15	IMPROVEMENTS			1993	6,920	177	39	177		2,202	15
16	IMPROVEMENTS			1994	21,365	548	39	548		6,177	16
17	ELECTRICAL			1996	3,351	86	39	86		849	17
18	NURSE STATION			1996	18,097	464	39	464		4,583	18
19	RAILS			1996	1,458	37	39	37		366	19
20	NEW CEILING			1996	14,883	382	39	382		3,771	20
21	WINDOW			1996	600	15	39	15		148	21
22	SHOWER ROOM VENTILATION			1996	575	15	39	15		148	22
23	NEW FLOORS			1996	15,709	403	39	403		3,980	23
24	ROOF			1996	23,100	592	39	592		5,402	24
25	PARKING LOT			1997	14,500	967	15	967		8,259	25
26	NEW STAIRCASE			1997	3,600	92	39	92		748	26
27	HOT WATER HEATER			1998	5,557	142	39	142		1,119	27
28	GREASE TRAP			1998	1,967	51	39	51		389	28
29	AWNINGS			1998	3,381	87	39	87		663	29
30	REPAIRS, PATCH, PAINT CEILING			1998	8,970	229	39	229		1,747	30
31	PAINTING, WALLCOVERING, BORDER PAPER			1999	25,619	657	39	657		4,298	31
32	TILING, HAND RAILS, PAINTING, WALL LIGHTS			1999	105,477	2,705	39	2,705		17,695	32
33	WALLCOVERINGS			1999	2,492	64	39	64		419	33
34	DOORS			1999	2,115	54	39	54		353	34
35	FAUCETS			1999	1,208	31	39	31		203	35
36	WALLCOVERINGS			1999	3,016	77	39	77		504	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINTING	1999	$ 1,422	$ 36	39	$ 36	$	$ 236	37
38	SIGNS	1999	1,327	34	39	34		222	38
39	WALLCOVERINGS, CHAIR RAILS, KICK PLATES	1999	19,179	492	39	492		3,218	39
40	PAINTING, WALLCOVERINGS, CHAIR RAILS	1999	15,420	395	39	395		2,584	40
41	CUTOM CABINETRY	1999	12,838	329	39	329		2,152	41
42	NEW SHED	1999	1,093	28	39	28		183	42
43	KICK PLATE, WALL BUMPER	1999	9,653	248	39	248		1,622	43
44	LIGHT FIXTURES	1999	380	10	39	10		65	44
45	WINDOWS	1999	51,312	1,316	39	1,316		8,609	45
46	WINDOW WELLS & WATERPROOFING	1999	4,560	117	39	117		765	46
47	LANDSCAPING	1999	38,175	2,545	15	2,545		16,649	47
48	WALLPAPERING	1999	922	24	39	24		157	48
49	SIGNS	1999	2,166	55	39	55		360	49
50	PAINTING & HANDRAILS	1999	2,262	58	39	58		379	50
51	REBUILD WALL & INSTALL WINDOWS	1999	1,409	36	39	36		236	51
52	WATERPROOFING	1999	3,220	83	39	83		543	52
53	NEW VENT FOR DRYER	1999	4,271	109	39	109		713	53
54	GENERATOR	2000	3,900	142	27.5	142		781	54
55	HOT WATER BOILER	2000	3,335	121	27.5	121		666	55
56	FIRE/SMOKE DAMPERS	2000	12,049	438	27.5	438		2,409	56
57	PVC BUMPERS,PAINTING	2000	5,337	476	7	762	286	4,793	57
58	ROOF	2001	8,860	322	27.5	322		1,463	58
59	AWNING	2001	9,135	332	27.5	332		1,508	59
60	CONCRETE	2001	4,242	283	15	283		1,285	60
61	PAVING PARKING LOT	2002	13,500	900	15	900		3,150	61
62	ROOF	2002	66,100	2,404	27.5	2,404		8,514	62
63	TILING IN 4 SHOWER ROOMS	2002	23,400	851	27.5	851		3,014	63
64	TUCKPOINTING	2002	9,360	340	27.5	340		1,204	64
65	ROOF TOP UNITS	2003	12,900	469	27.5	469		1,192	65
66	ROOF TOP UNITS	2003	5,100	185	27.5	185		470	66
67	HATCHES AND INTERIOR FIRE WALLS	2003	18,120	659	27.5	659		1,675	67
68	BLINDS	2003	993	95	5	199	104	597	68
69	HOT WATER BOILER	2004	6,420	233	27.5	233		437	69
70	TOTAL (lines 4 thru 69)		$ 2,762,676	$ 88,908		$ 89,210	$ 302	$ 1,165,717	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,762,676	$ 88,908		$ 89,210	$ 302	$ 1,165,717	1
2	GENERATOR	2004	25,000	909	27.5	909		947	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,787,676	$ 89,817		$ 90,119	$ 302	$ 1,166,664	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 152,197	$ 12,005	$ 14,881	$ 2,876	10	$ 88,486	71
72	Current Year Purchases	19,641	3,928	982	(2,946)	10	982	72
73	Fully Depreciated Assets	322,959					322,959	73
74								74
75	TOTALS	$ 494,797	$ 15,933	$ 15,863	$ (70)		$ 412,427	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT AND ACTIVITIES	1990 DODGE VAN	1990	$ 20,012	$	$	$		$ 20,012	76
77										77
78										78
79										79
80	TOTALS			$ 20,012	$	$	$		$ 20,012	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,643,910	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,750	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 105,982	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 232	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,599,103	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,401 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	EXE. DIRECTOR	2004 CADI DEVILLE	$ #######	$ 6,363	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 6,363	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 **#** 0031393 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	7,738		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	898,375		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,771		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	15,000		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 964,884	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	202,137		15
16	Equipment, at Historical Cost	84,754		16
17	Accumulated Depreciation (book methods)	(81,611)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 205,280	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,170,164	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 175,756	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,714,206		29
30	Accrued Salaries Payable	81,751		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	196,015		32
33	Accrued Interest Payable	2,975		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,170,703	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,170,703	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,000,539)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,170,164	$	48

***(See instructions.)**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,356,094)	1
2	Restatements (describe):		2
3	ROUNDING	8	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,356,086)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	355,547	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 355,547	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,000,539)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,379,471	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,379,471	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	3,902	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,902	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,383,373	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	667,436	31
32	Health Care	1,516,734	32
33	General Administration	960,777	33
	B. Capital Expense		
34	Ownership	822,106	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,773	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,027,826	40
41	**Income before Income Taxes (line 30 minus line 40)****	355,547	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 355,547	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
tax return is a combination of mo skokie, and skokie 1 & 2

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,720	6,280	$ 194,581	$ 30.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,252	15,276	430,636	28.19	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	36,477	39,450	407,324	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,404	7,147	74,048	10.36	10
11	Social Service Workers	10,363	11,459	146,885	12.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,018	14,978	132,748	8.86	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,551	17,910	157,247	8.78	18
19	Laundry	14,651	16,393	73,357	4.47	19
20	Administrator	992	1,072	40,063	37.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,090	1,097	13,863	12.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,518	131,062	$ 1,670,752 *	$ 12.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fees	$ 6,627	1-3	35
36	Medical Director	Monthly Fees	1,200	9-3	36
37	Medical Records Consultant	Monthly Fees	4,224	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fees	2,040	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	Monthly Fees	4,654	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,745		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EUGENE BERGER	ADMIN	0	$ 40,063
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 40,063

B. Administrative - Other

Description	Amount
PREMIER MANAGEMENT - MANAGEMENT FEES	$ 202,948
TOTAL (agree to Schedule V, line 17, col. 3)	$ 202,948
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
OMNICARE OF NORTHERN	DATA PROCESSING	$ 2,820
KRUPNICK, BOKOR,KAGDA	ACCOUNTING	7,625
THOMASHOW BROWN & PAIALI	ACCOUNTING	1,156
JOAN WILLEY	ADMIN CONSULTANT	4,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 15,601

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 21,849
Unemployment Compensation Insurance		15,809
FICA Taxes		125,981
Employee Health Insurance		147,188
Employee Meals		13,797
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		6,664
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		21,778
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 353,066

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,809
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	3,302
TRUST/FRANCHISE/CONTRIB/ETC	1,498
LICENSES & PERMITS	2,800
DUES & SUBSCRIPTIONS	6,237
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(1,498)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,302)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,846

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	11,848
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,848

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2001	$ 1,246	3 YRS	$ 415	$ 415	$ 208	$	$	$	$	$	$
2	PAINT/DECORATING	2004	1,500	3 YRS			250	500	500	250			
3	PAINT/DECORATING	2005	591	3 YRS				99	197	197	98		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,337		$ 415	$ 415	$ 458	$ 599	$ 697	$ 447	$ 98	$	$

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $4829**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **60,773**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **13,797** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees